STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GLEN ASSISTED LIVING COMMUNITY	2250 HARVEST MOON DR INDIANAPOLIS, IN 46229

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R000000	This visit was for the Investigation of Complaint IN00130037. Complaint IN00130037 - Substantiated. State residential finding related to the allegations is cited at R091. Survey dates: June 3 & 4, 2013 Facility number: 003916 Provider number: 003916 AIM number: N/A Survey team: Joyce Hofmann, RN Census bed type: Residential: 58 Total: 58 Census payor type: Other: 58 Total: 58 Sample: 3 These state findings are cited in accordance with 410 IAC 16.2. Quality review 6/11/13 by Suzanne Williams, RN	R000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R000091	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to implement their written policies and procedures in regard to resident rights and range of services offered, related to a housekeeping employee providing personal care to a resident, for 1 of 3 sampled residents reviewed for appropriate services and resident rights [Resident C]. Findings include: Resident C's clinical record was reviewed on 06/04/13 at 9:56 a.m. Resident C's diagnoses included, but were not limited to, urinary tract infection, glaucoma, acute bronchitis, deformity of left foot, carotid artery stenosis, osteoarthritis, intervertebral disc degeneration, and dyspnea. Resident C was interviewed on 06/04/13 at 12:35 p.m. and indicated	R000091	Based on interview and record review, the facility failed to implement their written policies and procedures in regard to resident rights and range of services offered, related to a housekeeping employee providing personal care to a resident, for 1 of 3 sampled residents reviewed for appropriate services and resident rights [Resident C]. ***What Corrective Action(s) will be accomplished for those Residents found to be affected by the deficient practice*?** 1. Housekeeper in question has been terminated for exceeding the scope of his job description.5/29/13. 2. Additional CNA put on all night shifts. 6/10/13. 3. With the community HR or ADM, all employees will review and re-sign their job descriptions with emphasis on scope and or penalty for exceeding scope of job practice. NLT 07/21/13. 4. In-service topics, June 10, 17, and 25th to	07/21/2013

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	on May 25, 2013, she had an accident during the night shift and had pushed her button for help. Resident C indicated a gentleman came into her room and "started to get me out of bed and took me to the bathroom." Resident C indicated she tried to wipe herself and the gentleman told her she wasn't clean enough and "took a wash cloth and wrapped it around his finger and penetrated my rectum." Resident C indicated she told him to "stop it" and he did and said, "I'm sorry." Resident C indicated the gentleman helped her back to bed and kneeled down and said something about the girl was a liar. Resident C indicated she did not know who he was talking about . Resident C indicated the gentleman had answered her button before and had always said he would get help before, but did not say that this time. Interview with the Administrator on 06/03/13 at 9:50 a.m. indicated he had been concerned over a reportable event he had reported to the State Department of Health where a housekeeper who worked nights had wiped a resident. The Administrator indicated he had explained to the housekeeper he could answer the resident's call lights and ask what was needed, but he		include verbal warning of our already standing prohibition against non-certified, non-licensed employees doing personal care of any kind. i.e. toileting, dressing, showering transferring, feeding and medication administration. 5. The Resident Rights Handbook has been read to Resident Council and entered into the meeting minutes on 6/11/13. 6. Audit confirming all residents have signed for their Resident Rights Handbooks completed 6/8/13. 7. Resident Council attendees will be queried for unauthorized care given beyond the scope of job description/licensing at monthly meetings starting in July 2013 and extending to July 2014. Results will be investigated and published in the monthly Resident Council Meeting Minutes. ***How will the Facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken.*** This was an isolated incident occurring with only one resident. The residents have been briefed their rights at the June Resident Council Meeting and attendees queried at the June meeting. In addition to a formal written complaint system, posted Ombudsman and State Agency phone numbers, an informal complaint system using a discrete and anonymous Complaint Box	

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	could not provide care to the residents and would need to get the QMA [Qualified Medication Assistant] to provide the care. The Administrator indicated the housekeeper had been told not to work out of his scope as a housekeeper and had voiced understanding. The Administrator indicated he terminated the housekeeper. Review of a written statement, dated 05/31/13, by CNA #2, who was the first person Resident C had confided in, indicated, "I was going to provide care for (Resident C) when I noticed her demnor (sic) was different. I asked (Resident C) what was wrong, she responded by saying 'who can I trust?' I quickly responded by saying 'me!' (Resident C) proceeded to tell me she had an accident on night shift and a gentleman came and cleaned her up. (Resident C) said after she was completely clean the gentleman proceeded to placing a towel around two fingers and penetrating her rectum. Her response was 'stop that' and he replied 'I'm sorry.' After (Resident C) finished the story I notified the nurse (charge nurse) on duty." Review of a written statement, by		and an open door policy with the Administrator and or Resident Care Coordinator also exists for reporting incidents. Associates have been encouraged to report as well at the 10 June In-service. Future June in-service meetings will also cover this topic as well. ***What Measures will be put in place or what systemic changes will the facility make to ensure that the deficient changes will not occur***. The facility already requires all new employees review and sign a lengthy and formal job description. In addition a formal associate review/re-signing of job descriptions has already begun with HR/Business Office Manager. To be completed NLT 7/21/13. ***How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place? And by what dates will these systemic changes be accomplished?*** For a period of one year, the Administrator and or his representative will query Resident Council once a month for care that exceeds its scope of practice. Is anybody out there providing care that they are not trained for or authorized to perform? The results of this question will be investigated and posted in the Council minutes for any and all to see and or review. In addition all of the other	

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	QMA #3, indicated, "On 5-25-13 @ approximately 9:30 a.m., the charge nurse told me to come to (Resident C's) room asap (as soon as possible). Writer entered room [number], charge nurse was sitting with resident. Asked resident to 'start from the beginning and tell (QMA #3) what you just told me.' Res (Resident) stated: 'When I first met (name of housekeeper), he told me that he couldn't provide personal care services. So, last night, when I paged (housekeeper) cleaned me up, wrapped a finger in a wash cloth and pushed it inside my rectum.' I said to (Resident C) 'What did you say to him when he did that?' (Resident C) answered 'Stop that!' I asked (Resident C) "What did he say to you after you told him to stop?" (Resident C) answered, 'I'm sorry.' ...Charge nurse informed DON and Admin (Administrator) via phone." Review of a written statement dated 05/25/13, by LPN #1, indicated, "Please note I was present when (Administrator) talked to (Resident C) in regard to incident that occurred on Fri night 5-24-13/5/25 am. Resident stated 'that man with the pony tail assisted me to the bathroom per my request. He cleaned me good, then I guess I still had BM and He wiped me		aforementioned complaint/grievance procedures and systems remain in place. i.e. Resident Council Meeting, a formal written complaint system, posted Ombudsman and State Agency phone numbers, an informal discrete and anonymous complaint system using the Complaint Box, and an open door policy with the Administrator and or Resident Care Coordinator exists. Associates have been encouraged to report as well. **Dates of completion** are listed behind each and every action above. Last (final) action for #7 listed above to be completed NLT July 2014.	

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	again. His finger went into my rectum.' Questioned if it hurt. Stated 'No.' Stated, 'I told him to stop & he did & said he was sorry.' Resident alert & cooperative. She denied any further contact with him." LPN #1 was interviewed on 06/04/14 at 10:30 a.m. and indicated she went with the Administrator to talk to Resident C about the allegation. LPN #1 indicated Resident C had told them she needed help going to the bathroom and the housekeeper told her he was not licensed and she said, "I got to go" and he helped her to the bathroom, wrapped his finger and put it up her rectum and she said he said he was sorry. LPN #1 indicated Resident C never mentioned sexual abuse and it was not reported to the police that she knew of. LPN #1 indicated they asked her three times if there was any pain and she said no. Interview with the Director of Nursing [DON] and Administrator on 06/04/13 at 2:30 p.m. indicated the housekeeper was suspended pending investigation and was terminated. The DON indicated the computer indicated the bathroom call light was on for one minute during the alleged incident before it was turned off. The DON indicated Resident C had been			

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	acting strange two days prior to the incident and the family was thinking it was her medications and had them reviewed. The facility did a toileting program on the resident and found out she was frequently asking to go to the bathroom, so the facility got an order for an urinalysis. The family was to pick it up, but waited two days and took it and it was frozen according to the lab, so they could not use the urine that was eventually taken in. The facility got an order for a stat urinalysis and the resident was found to have an urinary tract infection. During this time, while waiting on the urinalysis, the physician had started her on an antibiotic, Cipro 500 milligrams twice a day. Review of the Job Description for Housekeeper, signed on 01/18/2013 by the housekeeper, indicated the primary duty was to "Perform housekeeping duties to ensure the community is maintained in a safe, clean, comfortable manner." The job description lacked documentation of the housekeeper providing personal care to a resident. Review of the Job Description for Certified Nursing Assistant (CNA) dated 08/30/12, indicated, "The			

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	primary purpose of the Certified Nursing Assistant (CNA) is to provide personal care to residents in a manner conducive to their safety and comfort consistent with policies and procedures while complying with state, federal and all other applicable health care standards. Essential job functions include the following. ... Assists residents with bowel and bladder functions...." The facility's Admission Agreement presented upon admission indicated Accommodations and Services included, but were not limited to, "Staff. Company shall provide staff twenty-four (24) hours a day, to provide supervision of, and assistance to, Resident. Such supervision and assistance shall be for the safety of all residents and assistance to residents during an emergency. Staff may provide additional assistance with grooming and personal hygiene, meals, and orientation to the extent that such services are in accordance with Resident's Assessment/Service Plan, included in the Service Rate, and permitted by applicable law... Skilled Nursing Services. Company shall provide Residential Nursing Care services, as defined by Indiana Regulations for Residential Care			

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	Facilities. Depending on the level of care, such services may include assistance prophylactic and palliative care including application of creams and ointments, routine dressings, restorative nursing assistance including passive and active range of motion assistance, toileting care... Residential Nursing Care will be provided in accordance with Resident's Assessment and Service Plan and will be included in Resident's Monthly Fee and Service Rate...." This state residential finding is related to Complaint IN00130037.			